Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
NVS3069AGC NAME OF PROVIDER OR SUPPLIER SUNSHINE RETIREMENT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 316 LACY LANE LAS VEGAS, NV 89107						
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLE' CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5)				
Y 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments This Statement of Deficiencies was generated as a result of the state licensure complaint survey conducted at your facility on 12/16/08. The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006. The facility was licensed for 9 total beds, with 4 beds classified as Category 1 and 5 beds classified as Category 2 beds. The facility had the following endorsements: Residential facility for elderly or disabled persons Residential facility for persons with chronic illnesses The census at the time of the survey was 7. One sample resident file was reviewed and 0 employee files were reviewed. The following complaint was reviewed: NV00019389 - Unsubstantiated (with unrelated deficiencies #895, #896, #897, and #899). The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified at the time of the survey:			Y 000					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 04/02/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3069AGC 12/16/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 316 LACY LANE SUNSHINE RETIREMENT HOME LAS VEGAS, NV 89107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 895 Y 895 Continued From page 1 Y 895 Y 895 449.2744(1)(b)(1) Medication / MAR SS=D NAC 449.2744 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to record the type of medication administered to a resident (#1). Findings include: On 12/16/08 in the afternoon, Resident #1's file contained a "personal data" sheet with an admission date of 08/20/08. A hospice transfer order/care plan listed Resident #1's medication with the following detail: Zantac 150 milligrams by mouth twice daily Dexamethasone 4 milligrams by mouth mornings daily Tylenol 325 milligrams 1-2 tablets by mouth every 8 hours as needed for mild pain or headache

Roxanol 5 milligrams by mouth every hour as

Lorazepam .5 milligrams by mouth every 4 hours

needed for pain/shortness of breath

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
NVS3069AG(NVS3069AGC	B. WING			12/16/2008			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	1 2271	0,200		
SUNSHINE RETIREMENT HOME			316 LACY LANE LAS VEGAS, NV 89107						
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE				
Y 895	as needed for anxiety/shortness of breath Senna-S 1 tablet by mouth twice daily as needed for constipation Trazodone 100 milligrams by mouth at bedtime as needed for insomnia; may repeat once Oxygen at 2 Liters per minute via nasal cannula as needed for shortness of breath or dyspnea Resident #1's file lacked a medication administration record indicating administration of scheduled medications for August 2008. On 12/16/08 in the afternoon, the administrator indicated she did not remember Resident #1.		Y 895						
Y 896 SS=D	()() ()		to n was	Y 896					
	This Regulation is not met as evidenced by: Based on record review, the facility failed to record the date and time of medication administration to a resident (#1).								

PRINTED: 04/02/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3069AGC 12/16/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 316 LACY LANE SUNSHINE RETIREMENT HOME LAS VEGAS, NV 89107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 896 Y 896 Continued From page 3 Findings include: On 12/16/08 in the afternoon, Resident #1's file contained a "personal data" sheet with an admission date of 08/20/08. A hospice transfer order/care plan listed Resident #1's medication with the following detail: Zantac 150 milligrams by mouth twice daily Dexamethasone 4 milligrams by mouth mornings daily Tylenol 325 milligrams 1-2 tablets by mouth every 8 hours as needed for mild pain or headache Roxanol 5 milligrams by mouth every hour as needed for pain/shortness of breath Lorazepam .5 milligrams by mouth every 4 hours as needed for anxiety/shortness of breath Senna-S 1 tablet by mouth twice daily as needed for constipation Trazodone 100 milligrams by mouth at bedtime as needed for insomnia; may repeat once Oxygen at 2 Liters per minute via nasal cannula as needed for shortness of breath or dyspnea Resident #1's file lacked a medication administration record indicating administration of scheduled medications for August 2008.

Severity: 2 Scope: 1

SS=D

Y 897 449.2744(1)(b)(3) Medication / MAR

Y 897

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as needed for anxiety/shortness of breath

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Y 899

NAC 449.2744

SS=D

Severity: 2 Scope: 1

Y 899 449.2744(2) Medication Administration

2. The administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which each caregiver was responsible for assisting in the administration of medication to a resident. This requirement may be met by including on a resident's medication sheet an indication of who assisted the resident in the administration of the medication, if the caregiver can be identified from this indication.

This Regulation is not met as evidenced by:

administrations of medication for August 2008.

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as needed for shortness of breath or dyspnea

administration record indicating administration of scheduled medications for August 2008. The file failed to indicate who or if anyone administered Resident #1's scheduled medications for August

Resident #1's file lacked a medication

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